No. 99-547

FILED
NOV 19 1999
OFFICE OF THE CLERK
SUPREME COURT, U.S.

In The

Supreme Court of the United States

PALOMAR POMERADO HEALTH SYSTEM,
A HEALTH CARE DISTRICT,

Petitioner,

v.

KIMBERLY BELSHÉ, DIRECTOR OF THE
CALIFORNIA DEPARTMENT OF
HEALTH SERVICES; DIETER MERKLE;
AND CURTIS COTTON,

Respondents.

**On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit**

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

BILL LOCKYER
Attorney General
FRANK S. FURTEK
Supervising Deputy Attorney General
MARSHA A. BEDWELL*
Deputy Attorney General
1300 I St., Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-5207
Facsimile: (916) 324-8835
Counsel for Respondents
Diana M. Bontá, R.N., Dr. P.H.,
Director; Dieter Merkle; Curtis Cotton
**Counsel of Record*

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTION PRESENTED

Whether a health care district created by the State of California has standing to sue the State in federal court challenging on federal constitutional grounds the validity of state Medicaid regulations that limit reimbursement for services to the usual charge to the general public.

PARTIES TO PROCEEDINGS

The parties to the Court of Appeals proceeding are the following:

Petitioner: Palomar Pomerado Health System, A Health Care District

Respondents: Kimberly Belshè, Director of the California Department of Health Services [Diana M. Bontá, R.N., Dr. P.H., has replaced Kimberly Belshè, as Director of the California Department of Health Services; pursuant to Federal Rules of Civil Procedure, Rule 25(d), she should be substituted in the place of former Director Belshè]; Dieter Merkle; and Curtis Cotton

ATTORNEYS

Attorney for Petitioner:

Patric Hooper
California Bar No. 57343
Hooper, Lundy & Bookman, Inc.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2799
Telephone: (310) 551-8165
Facsimile: (310) 551-8181
**Counsel of Record*

PARTIES TO PROCEEDINGS – Continued

Attorneys for Respondents:

Bill Lockyer
Attorney General
Frank S. Furtek
Supervising Deputy Attorney General
Marsha A. Bedwell*
Deputy Attorney General
California Bar No. 94860
1300 I St., Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-5207
Facsimile: (916) 324-8835
Counsel for Respondents Diana M. Bontá, R.N., Dr. P.H., Director; Dieter Merkle; Curtis Cotton
**Counsel of Record*

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

BRIEF IN OPPOSITION 1

OPINIONS BELOW 1

STATEMENT OF JURISDICTION 1

STATUTES AND REGULATIONS 2

STATEMENT OF THE CASE 5

REASONS TO DENY THE WRIT 9

A. This Case Is Not Appropriate For Review Because State Court Proceedings May Resolve The Dispute 9

B. The Court Of Appeals Decision Is Not Inconsistent With Supreme Court Decisions Allowing Providers To Challenge State Medicaid Agency Actions 10

C. The Ninth Circuit Court Of Appeals' Rule That Political Subdivisions Of A State Lack Standing To Sue The State In Federal Court To Challenge The Validity Of State Regulations On Federal Constitutional Grounds Is Consistent With Supreme Court Authority 12

CONCLUSION 17

TABLE OF AUTHORITIES

Page

CASES

Alden v. Maine, ___ U.S. ___, 119 S.Ct. 2240 (1999) 16

ASARCO, Inc. v. Kadish, 490 U.S. 605 (1988) 9, 17

Burbank-Glendale-Pasadena Airport Authority v. City of Burbank, 136 F.3d 1360 (9th Cir. 1998) 12, 15

City of Newark v. New Jersey, 262 U.S. 192 (1923) 13

City of Trenton v. New Jersey, 262 U.S. 182 (1923)....13, 16

City of South Lake Tahoe v. California Tahoe Regional Planning Agency, 625 F.2d 231 (9th Cir. 1980)...12, 13

Dept. of Commerce v. U.S. House of Representatives, 119 S.Ct. 765 (1999) 11

Director, Office of Workers' Compensation Program v. Perini North River Associates, 459 U.S. 299 (1983) 11

Folden v. Washington State DSHS, 981 F.2d 1054 (9th Cir. 1992)..... 15

Folden v. Washington State DSHS, 744 F.Supp. 1507 (W. Wash. 1990) 15

Hunter v. City of Pittsburg, 207 U.S. 161 (1907)..... 13

Palomar Pomerado Health Systems v. Belshe, et al., 180 F.3d 646 (9th Cir. 1999)..... 1

Printz v. United States, 521 U.S. 898 (1997).....14, 16

South Macomb Disposal Authority v. Township of Washington, 790 F.2d 500 (6th Cir. 1986)..... 13

Testa v. Katt, 330 U.S. 386 (1947) 16

Trustees of Dartmouth College v. Woodward, 17 U.S. (4 Wheat.) 518 (1819)..... 13

TABLE OF AUTHORITIES – Continued

Page

White Mountain Apache Tribe v. Williams, 810 F.2d 844 (9th Cir. 1984) 15

Wilder v. Virginia Hospital Association, 496 U.S. 498 (1990) 10, 11, 12

Will v. Michigan Dept. of State Police, 491 U.S. 58 (1988) 11

Williams v. Mayor and City Council of Baltimore, 289 U.S. 36 (1933) 13

CONSTITUTIONAL PROVISIONS

U.S. Const. amend. XI 10

U.S. Const. amend. XIV 8

U.S. Const. Art. VI, cl. 2 ..... 8, 16

STATUTES

42 United States Code

§ 1396 et seq. 2

§ 1396a(a)(13)(A) 3, 6

§ 1396a(a)(30) 8

§ 1983 ..... 11, 12, 15

California Code Civil Procedure

§ 1094.5 9

Health & Safety Code

§§ 32000 et seq. 5

Welfare and Institutions Code

§§ 14000 et seq. 2

§ 14170 ..... 5, 7

TABLE OF AUTHORITIES – Continued

Page

§ 14171, subd. (a) 5

§ 14171, subd. (j) 5

§ 14177 7

REGULATIONS

California Code of Regulations

§ 51480(a) 5, 7

§ 51501(a) 4, 7

§ 51511(a)(2) 4, 6, 7

OTHER AUTHORITIES

Public Law

No. 96-499, § 962(a), 94 Stat. 2650 (1980) 3

No. 105-33, § 4711 3

No. 105-33, § 4711(a), 111 Stat. 251, 507-08 (1997) ... 3, 6

No. 105-33, § 4711(d) 3

BRIEF IN OPPOSITION

Respondents respectfully file this brief in opposition to the Petition For Writ Of Certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The Ninth Circuit Court of Appeals opinion, reported at *Palomar Pomerado Health Systems v. Belshè, et al.*, 180 F.3d 646 (9th Cir. 1999), is included at Appendix 1 through 14. The United States District Court Memorandum of Opinion and Order and Judgment, March 30, 1998, is included at Appendix 15-31.

STATEMENT OF JURISDICTION

Respondents concur in the jurisdictional statement of Petitioner with the following additions. On June 29, 1999, the Ninth Circuit Court of Appeals vacated the District Court decision and dismissed the appeal on the jurisdictional ground that Petitioner, as a political subdivision of the State of California, lacks standing to bring an action against the State challenging the validity of state regulations on due process and Supremacy Clause grounds. The Ninth Circuit Court of Appeals denied Petitioner's petition for rehearing and suggestion for rehearing en banc on September 15, 1999.

STATUTES AND REGULATIONS

This case involves administration of the Medicaid program, Title XIX of the Social Security Act, 42 U.S.C. sections 1396 et seq. Medicaid is a program jointly administered by the Federal and State governments for the purpose of providing medical services to persons with low incomes. In California, the Medicaid program is known as Medi-Cal and is administered by the California Department of Health Services ("Health Services"), pursuant to California Welfare and Institutions Code sections 14000 et seq.

Beginning in 1980 and continuing up to October 1, 1997, the Boren Amendment governed reimbursement rates for services, including long-term care services, providing that a state plan for services must:

> "Provide . . . for payment . . . of the hospital services, nursing facilities services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality . . . ."

Former U.S.C. § 1396a(a)(13)(A); Omnibus Budget Reconciliation Act of 1980, Pub. L. 96-499, § 962(a), 94 Stat. 2650 (1980). The Boren Amendment was repealed by the Balanced Budget Act of 1997, Public Law No. 105-33, section 4711(a) (42 U.S.C. § 1396a(13), 111 Stat. 251, 507-08 (1997)). With regard to reimbursement rates, section 4711 provides that the state plan shall provide:

> "(a) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which –
>
> > "(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,
> >
> > "(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,
> >
> > "(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and
> >
> > "(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs;"

Section 4711, subdivision (d), provides:

> (d) EFFECTIVE DATE. – This section shall take effect on the date of the enactment of this Act

> and the amendments made by subsections (a) and (c) shall apply to payment for items and services furnished on or after October 1, 1997.

Health Services has promulgated regulations implementing the Medi-Cal program. California Code of Regulations, Title 22, section 51511(a)(2), establishes a generally applicable reimbursement rate for services provided in distinct part nursing facilities ("DP/NFs"), such as Palomar Pomerado's, as follows:

> "For nursing facilities that are distinct parts of acute care hospitals, if such facilities are not state operated, the per diem reimbursement rate that shall be the lesser of the facilities costs as projected by the Department or $214.90."

By regulation, California prohibits a provider from billing Medi-Cal more than what the provider charges a member of the general public for similar services:

> "Notwithstanding any other provision of these regulations, no provider shall charge for any service or any article more than would have been charged for the same service or article to other purchases of comparable services or articles under comparable circumstances."

Title 22, Cal. Code Regs. § 51501(a).

Similarly, California prohibits a Medi-Cal provider from submitting a claim for reimbursement in an amount that is higher than what is usually charged to the general public:

> "No provider shall bill or submit a claim for reimbursement for the rendering of health care services to a Medi-Cal beneficiary in any amount greater or higher than the usual fee

> charged by the provider to the general public for the same service."

Title 22, Cal. Code Regs. § 51480(a).

Welfare and Institutions Code section 14170 provides:

> "Amounts paid for services provided to Medi-Cal beneficiaries, shall be audited by the department in the manner and form prescribed by the department . . . ."

Welfare and Institutions Code section 14171, subdivision (a), provides, in part:

> "The director shall establish administrative appeal processes to review grievances or complaints arising from the findings of an audit . . . made pursuant to sections 10722 and 14170 . . . "

from an audit or finding.

Welfare and Institutions Code section 14171, subdivision (j) provides:

> "The final decision of the director shall be reviewable in accordance with section 1094.5 of the Code of Civil Procedure within six months of the issuance of the director's final decision."

STATEMENT OF THE CASE

As a health care district formed under the Local Health Care District law (Health & Safety Code § 32000 et seq.), Palomar Pomerado is a political subdivision of the

State of California. It operates two skilled nursing facilities: Palomar Pomerado Continuing Care Facility, which is a part of the district's Palomar Medical Center, and Villa Pomerado, which is a part of the district's Pomerado Hospital. Each nursing facility is a distinct part nursing facility ("DP/NF"). Appendix at 2. Palomar Pomerado serves privately insured patients, Medi-Cal patients, and uninsured patients who pay from their own resources. Appendix at 2.

In April of 1994, Palomar Pomerado implemented a patient billing system that billed patients at a flat rate, based on the type of room occupied. Appendix at 2. At the same time, it implemented a "prompt pay discount" for private pay patients and patients who were privately insured. Patients who paid their bills within thirty days received a fifty percent discount. Appendix at 2. Palomar Pomerado does not offer the discount to Medi-Cal. Appendix at 2.

For services provided before October 1, 1997, that portion of the Medicaid law known as the Boren Amendment (42 U.S.C. § 1396a(a)(13)(A) (repealed by Pub. L. No. 105-33, § 4711(a), 111 Stat. 251, 507-08 (1997)), required a state to establish reimburse rates for providers of skilled nursing facility services such as Palomar Pomerado that are " 'reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.' " Appendix at 3. California complied with the Boren Amendment by establishing a prospective per diem reimbursement rate based on the lesser of a facility's costs or the median rate for all facilities in the class. Title 22, Cal. Code Regs. § 51511(a)(2). Appendix at 3. For the year beginning August 1, 1994, the

rate paid to a DP/NF was to be, "the lesser of the facility's costs as projected by the Department of Health Services or $214.90." Title 22, Cal. Code Regs. § 51511(a)(2). Appendix at 3.

By separate regulation, California prohibits a provider from billing Medi-Cal more than what the provider charges a member of the general public for similar services. Title 22, Cal. Code Regs. § 51501(a). Similarly, by regulation California prohibits a Medi-Cal provider from submitting a claim to Health Services in an amount higher than that usually charged to the general public. Title 22, Cal. Code Regs. § 51480(a), Appendix at 3. Thus, the result is that while California has established a reimbursement rate that applies generally to DP/NFs, that rate will not apply if its usual charge to the general public is less.

Health Services is authorized to conduct audits of providers, and to recover overpayments resulting from amounts paid in excess of the amounts usually charged by a provider. (Welf. & Inst. Code §§ 14170 and 14177.) Health Services audited the records of Palomar Pomerado's facilities for fiscal year ending June 30, 1994, and found that the discounted rate under the prompt payment program was Palomar Pomerado's "usual fee." Appendix at 3. Accordingly, it issued adjustments to recover the resulting overpayments based on evidence of discriminatory billing. Appendix at 3.

Palomar Pomerado filed an administrative appeal, challenging the recoupment. Appendix at 3. On February 24, 1997, while the administrative appeals were pending, Palomar Pomerado filed suit in federal court, seeking to enjoin Health Services and its agents from reducing the

Medi-Cal payment amounts owed Palomar Pomerado for benefits provided to Medi-Cal patients to the "discounted rates" charged private pay and privately insured patients. In addition, Palomar Pomerado sought an order declaring the practice and policy of Health Services to be violative of the Federal Medicaid law, regulations and the United States Constitution. Appendix at 4.

Health Services moved for summary judgment on September 5, 1997. Appendix at 6. On March 30, 1998, the District Court rejected Palomar Pomerado's assertions that Health Services' regulations and practices violated the Boren Amendment and the district's alleged due process rights. Appendix at 4. Palomar Pomerado made no argument that Health Services regulations and practices violated provisions of section 1396a(a)(30). Appendix at 16.

On appeal, Health Services, in addition to arguing the merits, argued that Palomar Pomerado, as a political subdivision of the state, lacked standing to sue in federal court challenging the validity of state regulations as violative of the Due Process Clause, U.S. Const. amend. XIV, or the Supremacy Clause, U.S. Const. art. VI, cl. 2. Appendix at 5. Thereafter, the Court of Appeals issued its decision dismissing the appeal and vacating the trial court's decision. Appendix at 9. A Suggestion for Rehearing En Banc was denied as reported by Palomar Pomerado in its Statement of the Case. Appendix at 7.

REASONS FOR DENYING THE WRIT

A. THIS CASE IS NOT APPROPRIATE FOR REVIEW BECAUSE STATE COURT PROCEEDINGS MAY RESOLVE THE DISPUTE.

When faced with Health Services' decision to limit its reimbursement to Palomar Pomerado's usual and customary charge to the general public (as reflected in its "prompt payment" discounted rate), Palomar Pomerado exercised its appeal rights provided by state law. Appendix at 3 to 4. The appeal was not completed in the state administrative forum until April 26, 1999. Appendix at 4. Thereafter, on July 7, 1999, Palomar Pomerado filed an action in state court seeking review of Health Services' administrative proceedings in this matter, by way of "Petition for Writ of Mandate" pursuant to Code Civil Procedure section 1094.5, which remains pending. Appendix at App. 32. Thus, the California courts will review the actions of Health Services in this matter.

Palomar Pomerado is entitled to raise in the state forum any of the contentions it has concerning inconsistencies with federal law, including the alleged inconsistencies of the California regulations and the Boren Amendment. California Courts have authority to decide questions interpreting and applying federal Medicaid law, as well as to issue binding interpretations without concern for federal standing requirements. *ASARCO, Inc. v. Kadish*, 490 U.S. 605, 617 (1988).

Furthermore, the administrative proceedings and accompanying judicial review may result in resolution in a manner that makes resolution of the question Palomar

Pomerado brings to this Court wholly unnecessary. For example, if the state court were to finally determine that the discounted rate was not the "usual charge," that recovery of alleged overpayments was barred on procedural grounds, or that the California regulations are inconsistent with federal Medicaid law, this case would come to an end. In addition, the state court is capable of giving more complete relief because the Eleventh Amendment (U.S. Const. Amend. XI) does not operate as a bar to relief in state court. Because of the repeal of the Boren Amendment, prospective federal court injunctive relief based on inconsistency between the state regulations and federal law may no longer be available or meaningful by the time this case is decided. Thus, the question may never require resolution in these circumstances. For this reason, the court should deny the writ.

B. THE COURT OF APPEALS' DECISION IS NOT INCONSISTENT WITH SUPREME COURT DECISIONS ALLOWING PROVIDERS TO CHALLENGE STATE MEDICAID AGENCY ACTIONS

Palomar Pomerado attempts to cast this case as one in which the Court must decide whether or not California can be required to conform its Medi-Cal program to the requirements of federal medicaid law. Appendix at 8-9. That is not the issue. Participating states, including California, are required to comply with the requirements of the Medicaid Act and its implementing regulations. *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 502 (1990) ["*Wilder*"]. The question this case presents is whether Palomar Pomerado, a health care district created by the State of California, has standing to sue the state in federal

court alleging that state regulations are invalid on federal constitutional grounds.

The Ninth Circuit Court of Appeals correctly answered "no," and Palomar Pomerado's reliance on *Wilder* is misplaced. *Wilder* addressed the question of whether the Boren Amendment created a private right of action enforceable under 42 U.S.C. § 1983. *Wilder*, 496 U.S. at 508. The court determined that the Boren Amendment imposed "a binding obligation on States . . . to adopt reasonable and adequate rates" that was enforceable by health care providers, relying significantly on the amendment's requirement that states make findings and assurances to that effect. *Wilder*, 496 at 512-513.

Wilder does not address the issue of plaintiff's standing to bring the case in federal court. The plaintiff was not a political subdivision of the state, but rather a non-profit corporation, consisting of private and public hospitals. *Wilder*, 496 U.S. at 503. No issue of standing appears to have been raised, and even if it had been, the presence of private hospital providers would have avoided any standing concern (assuming no issue of the non-profit association's representational standing arose). The presence of one party with standing before the court assures that a controversy is justiciable and the federal court may hear it. *Dept. of Commerce v. U.S. House of Representatives*, 119 S.Ct. 765, 773 (1999) citing *Director, Office of Workers' Compensation Program v. Perini North River Associates*, 459 U.S. 299, 303, 305 (1983). Furthermore, this court has more than once declared that it "has never considered itself bound [by prior *sub silentio* holdings] when a subsequent case finally brings the jurisdictional issue" before it. *Will v. Michigan Dept. of State Police*, 491 U.S. 58, 63, n. 4

(1988) (holding that a State is not a person within the meaning of 42 U.S.C. § 1983, notwithstanding prior court decisions granting relief against states and state officials when the underlying definitional question of whether a state and its officials was not addressed). Thus, *Wilder* is not binding authority on the question of political subdivision standing for federal court suits against states and offers Palomar Pomerado no aid.

C. THE NINTH CIRCUIT COURT OF APPEALS' RULE THAT POLITICAL SUBDIVISIONS OF A STATE LACK STANDING TO SUE THE STATE IN FEDERAL COURT TO CHALLENGE THE VALIDITY OF STATE REGULATIONS ON FEDERAL CONSTITUTIONAL GROUNDS IS CONSISTENT WITH SUPREME COURT AUTHORITY

The Ninth Circuit applies a "per se" rule that political subdivisions of a state lack standing to bring federal constitutional challenges to state law in federal court. Appendix at 5. In the case of *City of South Lake Tahoe v. California Tahoe Regional Planning Agency*, 625 F.2d 231, 233 (9th Cir. 1980) ("*City of South Lake Tahoe*"), the court applied the rule to defeat claims of a city that a state statute violated the Fifth and Fourteenth amendments. Most recently, in *Burbank-Glendale-Pasadena Airport Authority v. City of Burbank*, 136 F.3d 1360, 1363-64 (9th Cir. 1998) ("*Burbank*") this court held that the rule applied equally to Supremacy Clause challenges to state laws brought by political subdivisions. This case does not provide occasion to reach a different conclusion on the point of law.

As set forth in *City of South Lake Tahoe*, the rule is based on federal constitutional law, established in a long line of cases declaring that political subdivisions do not have privileges and immunities to assert against a state. See *Hunter v. City of Pittsburgh*, 207 U.S. 161, 178-79 (1907); *Williams v. Mayor and City Council of Baltimore*, 289 U.S. 36, 40 (1933); *City of Trenton v. New Jersey*, 262 U.S. 182, 188 (1923); *City of Newark v. New Jersey*, 262 U.S. 192 (1923). The rule derives from the inherent nature of a political subdivision as an entity subordinate to its creator, the state. *Williams*, 289 U.S. at 40. As stated in *City of Trenton v. New Jersey*, 262 U.S. at 187, "municipalities have no inherent right of self-government which is beyond the legislative control of this state. A municipality is merely a department of the state, and the state may withhold, grant or withdraw powers and privileges as it sees fit." (footnote omitted.) This principle was earlier recognized in *Trustees of Dartmouth College v. Woodward*, 17 U.S. (4 Wheat.) 518 (at 628, 659-61, 668-70, 1819), which, in distinguishing between private corporations and municipalities, noted that "because municipal bodies are essentially creatures of the state and . . . the state retains the inherent power to alter, change, or even to abolish them in accordance with the state's constitution and laws . . . , the United States Constitution simply does not concern itself with matters of internal disagreements between a state and subdivisions created by it or between subdivisions created by the same state, for this area involves matters which the state is uniquely competent to resolve." *South Macomb Disposal Authority v. Township of Washington*, 790 F.2d 500, 507 (6th Cir. 1986), concurring

opinion of J. Engel. The United States Supreme Court has not overruled this line of authority.

The standing rule that precludes political subdivision suits in federal court on federal constitutional grounds also serves our constitutional design of dual sovereignty, in which states retain "a residuary and inviolable sovereignty." *Printz v. United States*, 521 U.S. 898, 918-919 (1997) (striking down provisions of the Brady Handgun Violence Prevention Act that required local law enforcement officers to perform background checks and related tasks). As a rule of standing, operative in the federal courts, the per se rule avoids intrusion into intra-state controversies and leaves to states and state courts, in the first instance, resolution of problems created by the exercise of state sovereignty.

Political subdivision challenges based upon the Supremacy Clause do not require a different standing rule. Supremacy Clause challenges, at least as to the issue of a political subdivision's standing, are not materially different in character than other federal court constitutional challenges to state statutes by political subdivisions of a state. In any such case, permitting a subordinate state entity to challenge a state enactment in federal court on federal constitutional grounds gives the subdivision power to trump the authority of the sovereign state. Whether the basis for complaint is the Supremacy Clause or other federal constitutional ground, such a challenge gives the subordinate the power to turn upside down the relationship of subordinate to sovereign – quite possibly in derogation of or in direct conflict with the powers and duties imposed upon the subordinate by the

State, thereby implicating federalism concerns. See, *Burbank*, 136 F.3d at 1364-65, concurring opinion of J. Kozinski.

It is not necessary to void the political subdivision standing rule in Supremacy Clause challenges. While it is said that "Supremacy Clause claims protect the interests of the federal government against encroachment by states" (*Burbank*, 136 F.3d at 1364), not all Supremacy Clauses challenges are of the same character. *White Mountain Apache Tribe v. Williams*, 810 F.2d 844, 858 (9th Cir. 1984), (holding that preemption of a state law under the Supremacy Clause, when based upon federal occupation of the field or conflict with federal goals does not support an action under 42 U.S.C. § 1983). Federal court consideration of such a case might be consistent with the interests of federalism where, for example, a political subdivision's challenge is to a state statute purportedly in direct conflict with the explicit provisions of a preemptive federally administered law based on the Commerce Clause. But, the circumstances of this case are different: this is a case alleging inconsistency between federal and state law in Medi-Cal – a cooperative state-federal program that gives the states broad authority to structure a plan for implementation. *Folden v. Washington State Department of Social and Health Services*, 744 F.Supp. 1507, 1529 (W. Wash. 1990); aff'd, *Folden v. Washington State Department of Social and Health Services*, 981 F.2d 1054 (9th Cir. 1992) A per se rule avoids deciding when a political subdivision should be permitted to challenge a state statute in federal court on Supremacy Grounds and when it should not.

Nor is Palomar Pomerado's argument that political subdivisions providers of Medi-Cal services are no different from private providers (Appendix at 13-15) entitled to any weight. This appears an argument that a political subdivision provider ought to have the same right to sue in federal courts as a private provider because it, in essence, acts in a proprietary manner in providing services to recipients. But this court has rejected the distinction between "private and proprietary" when dealing with political subdivisions' constitutional claims in federal court because of the nature of the relationship that exists between a State and its subordinate entities. *City of Trenton, 262 U.S.* at 188 (rejecting the city's claim that it was entitled to divert Delaware River without payment of a State license fee, as had been the case in a city contract with a private water company).

But application of the political subdivision rule does not mean that Medi-Cal beneficiaries served by public institutions will be treated differently than those served by private providers, as Palomar Pomerado suggests. State's and state officials cannot escape their duty to comply with supreme federal law. First, "States and their officers are bound by obligations imposed by the Constitution and federal statutes that comport with the constitutional design." *Alden v. Maine*, ___ U.S. ___, 119 S.Ct. 2240, 2266 (1999). In addition, state courts are bound by the Supremacy Clause itself which commands that "judges in every state shall be bound [by federal law]," and must, therefore, apply federal law. U.S. Const. Art. VI, cl. 2; *Printz v. United States*, 521 U.S. at 898, 928-29 (1997). State courts cannot refuse to enforce federal law. *Testa v. Katt*, 330 U.S. 386 (1947) (holding that the Rhode

Island state courts were required to enforce the provisions of the Federal Emergency Price Control Act). Furthermore, State courts have authority to render binding interpretations of federal Medicaid Law, and state courts are not bound by "the limitations of a case or controversy or other federal rules of justiciability . . . when they address issues of federal law" (*ASARCO Inc. v. Kadish*, 490 U.S. at 617), including federal standing requirements. Thus, there can be no argument that foreclosing federal court review will mean that California will escape its obligation to comply with federal law.

CONCLUSION

For the reasons set forth above, the writ should be denied.

Respectfully submitted,

BILL LOCKYER
Attorney General
FRANK S. FURTEK
Supervising Deputy Attorney General
MARSHA A. BEDWELL*
Deputy Attorney General
1300 I St., Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-5207
Facsimile: (916) 324-8835
Counsel for Respondents
Diana M. Bontá, R.N., Dr. P.H., Director; Dieter Merkle; Curtis Cotton
**Counsel of Record*

APPENDIX

PALOMAR POMERADO HEALTH SYSTEM, a Health Care District, Plaintiff-Appellant,

v.

Kimberly BELSHE; Dieter Merkle; Curtis Cotton,[1] Defendants-Appellees.

No. 98-15794.

United States Court of Appeals,
Ninth Circuit.

Argued and Submitted May 12, 1999.

Decided June 29, 1999.

Patric Hooper, Hooper, Lundy & Bookman, Los Angeles, California, for plaintiff-appellant.

Marsha Ann Bedwell, Deputy Attorney General, Sacramento, California, for defendants-appellees.

Appeal from the United States District Court for the Eastern District of California; David F. Levi, District Judge, Presiding. D.C. No. CV-97-00294-DFL.

Before: LAY,[2] PREGERSON, and HAWKINS, Circuit Judges.

---

[1] Defendant Belshe is the Director of the California Department of Health Services. Defendants Merkle and Cotton are auditors employed by the department.

[2] The Honorable Donald P. Lay, Senior United States Circuit Judge for the Eighth Circuit, sitting by designation.

Opinion by Judge PREGERSON; Concurrence by Judge HAWKINS.

PREGERSON, Circuit Judge:

This action arises out of a California Department of Health Services ("DHS") audit of Plaintiff Palomar Pomerado Health System's billing practices.

DHS asks us to decide whether a health care district created by the State of California has standing to sue the state in a federal court to challenge the validity of state regulations on federal constitutional grounds. We answer in the negative.

I.

Palomar Pomerado is a health care district formed under California law. It provides long-term health care services at two "distinct part nursing facilities"[3] in San Diego County, California. Palomar Pomerado provides services to privately insured patients, Medi-Cal patients, and uninsured patients who pay on their own.

In April 1994, Palomar Pomerado switched from a billing system based on the level of care the patient required to a "flat rate" system based on the type of room the patient occupied. At the same time, Palomar Pomerado introduced a "prompt pay discount" for

---

[3] A "distinct part nursing facility" operates as a distinct part of a hospital as opposed to a freestanding nursing facility which is not part of a hospital. Palomar Pomerado's two distinct part facilities are Palomar Continuing Care Center, a distinct part of Palomar Medical Center, and Villa Pomerado, a distinct part of Pomerado Hospital.

patients who paid privately or who were privately insured. Palomar Pomerado does not offer the discount to Medi-Cal. Under the prompt pay discount policy, patients who paid their bills within thirty days receive a fifty percent discount.

The Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A) (repealed by Pub.L. No. 105-33, § 4711(a), 111 Stat. 251, 507-08 (1997)), requires states to reimburse providers such as Palomar Pomerado at a rate that is "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." In California, reimbursement is governed by Title 22, California Code of Regulations, section 51511(a)(2). Section 51511(a)(2) provides that the per diem reimbursement rate for distinct part nursing facilities such as Palomar Pomerado "shall be the lesser of the facility's costs as projected by [DHS] or $214.90."

A separate California regulation prohibits providers such as Palomar Pomerado from submitting "claim[s] for reimbursement for the rendering of health care services to a Medi-Cal beneficiary in any amount greater or higher than the usual fee charged by the provider to the general public for the same service." 22 C.C.R. § 51480(a). DHS enforces section 51480(a) through annual audits. Following an audit for Fiscal Year Ending ("FYE") June 30, 1994, DHS found that the discounted rate under the "prompt pay" program was Palomar Pomerado's "usual fee" and concluded that Palomar Pomerado had overcharged the state by $558,000 for the period between April 1, 1994 and June 30, 1994. Accordingly, DHS brought an administrative recoupment action. Palomar Pomerado filed an administrative appeal on grounds separate from those

Palomar Pomerado raises here.[4] Since the FYE June 30, 1994 audit, DHS has continued to enforce 22 C.C.R. § 51480(a) against Palomar Pomerado.

On February 24, 1997, Palomar Pomerado brought this action against DHS to permanently enjoin defendants and their agents "from reducing the Medi-Cal payment rates owing to Palomar Pomerado for distinct part skilled nursing facilities services furnished to Medi-Cal patients below the rates required to be paid under . . . federal Medicaid law, including enjoining them from reducing reimbursement to the discounted [rates]" charged under the prompt pay program to patients who pay privately or who are insured privately. Palomar Pomerado also sought "an order declaring the practice and policy of [DHS] . . . to be in violation of the federal Medicaid law and regulations and the United States Constitution," and "an order declaring that plaintiff is entitled to provide a prompt-pay discount to its private-pay patients without jeopardizing its right to receive Medi-Cal payments [from the state] at the rates . . . contained in 22 CCR Section 51511." Palomar Pomerado also sought reimbursement for the costs of its action and for its attorneys' fees.

On September 5, 1997, DHS moved for summary judgment. On March 30, 1998, the district court determined that DHS's practices were consistent with the Boren Amendment, and that DHS had not violated Palomar Pomerado's due process rights. Accordingly, the

---

[4] Palomar's administrative appeal was decided on April 26, 1999.

district court granted DHS's motion for summary judgment. Palomar Pomerado appeals. We dismiss for lack of standing.

II.

On appeal, DHS argues for the first time that Palomar Pomerado, as a political subdivision of the state, has no standing to sue the state in federal court to challenge the validity of state regulations as violative of the Due Process Clause, U.S. Const. amend. XIV, or the Supremacy Clause, U.S. Const. art. VI, cl. 2.

It is well-settled that "[s]tanding is a necessary element of federal-court jurisdiction." *City of South Lake Tahoe v. California Tahoe Reg'l Planning Agency*, 625 F.2d 231, 233 (9th Cir.1980) (citing *Warth v. Seldin*, 422 U.S. 490, 498, 95 S.Ct. 2197, 45 L.Ed.2d 343 (1975)). This jurisdictional issue is not waived because it was not raised in the district court. *See South Lake Tahoe*, 625 F.2d at 233 ("Although the district court passed over the standing issue we must consider it because it governs our jurisdiction as well.").

A.

Under established Ninth Circuit law, "[p]olitical subdivisions of a state may not challenge the validity of a state statute" in a federal court on federal constitutional grounds. *Id.* (quoting *City of New York v. Richardson*, 473 F.2d 923, 929 (2d Cir.1973)); *see also Burbank-Glendale-Pasadena Airport Auth. v. City of Burbank*, 136 F.3d 1360, 1363-64 (9th Cir.1998) (holding that the rule of *South Lake*

Tahoe applies to both Fourteenth Amendment and Supremacy Clause claims.) "This is true whether the defendant is the state itself or another of the state's political subdivisions." *South Lake Tahoe*, 625 F.2d at 233 (citations omitted).

Palomar Pomerado's claims are based on Fourteenth Amendment and Supremacy Clause grounds. We must determine (1) whether Palomar Pomerado is a "political subdivision" of the State of California, and if so, (2) whether, by suing the defendants named in this action, Palomar Pomerado brings this action against the state.

B.

Palomar Pomerado is a health care district. It is a public corporation formed under California law. *See* Cal. Health & Safety Code § 32000 *et seq.* (Local Health Care District Law). Its powers are limited to those granted it by the state. *See* Cal. Health & Safety Code § 32001.

Among its powers, Palomar Pomerado may "establish, maintain, and operate" health facilities. *See* Cal. Health & Safety Code § 32121(j). To meet this end, Palomar Pomerado possesses and exercises limited governmental functions within a particular area of the state. For example, Palomar Pomerado possesses the power to levy taxes and issue bonds. *See* Cal. Health & Safety Code §§ 32200-32243, 32316-32321. It also has the power of eminent domain. *See* Cal. Health & Safety Code § 32121(d). As such, it is a "political subdivision" and an agency of the state. *See* 58 Cal. Jur.3d § 12 ("all public corporations exercising governmental functions within a

limited portion of the state – counties, cities, reclamation districts, irrigation districts – are agencies of the state").

Such political subdivisions, like "[m]unicipal corporations[,] have generally been denied standing in the federal courts to attack state legislation as violative of the federal Constitution, on the ground that they have no rights against the state of which they are a creature." *Hart and Wechsler's The Federal Courts and The Federal System* 180 (Richard H. Fallon et al., eds.1996).

In sum, Palomar Pomerado is a creature of the state. Counsel for Palomar Pomerado conceded at oral argument that the district continues to exist at the pleasure of the state, its legislature, and its citizens. Moreover, Palomar Pomerado's powers are limited to those granted by the state. *See* Cal. Health & Safety Code § 32001. Finally, as stated above, Palomar Pomerado possesses and exercises governmental functions. Accordingly, Palomar Pomerado is a "political subdivision" for purposes of the standing doctrine discussed in *South Lake Tahoe*.

C.

Palomar Pomerado argues that we should not apply *South Lake Tahoe* because Palomar Pomerado brings this action against named state employees and not against the state. But as the following discussion indicates, Palomar Pomerado's action is in fact an action against the State of California.

" '[T]he general rule is that relief sought nominally against [a state] officer is in fact against the sovereign if

the decree would operate against the latter.' " *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 101, 104 S.Ct. 900, 79 L.Ed.2d 67 (1984) (quoting *Hawaii v. Gordon*, 373 U.S. 57, 58, 83 S.Ct. 1052, 10 L.Ed.2d 191 (1963) (per curiam)); *Dugan v. Rank*, 372 U.S. 609, 620, 83 S.Ct. 999, 10 L.Ed.2d 15 (1963) (an action is against the state "if the judgment sought would expend itself on the public treasury or domain, or interfere with the public administration, or if the effect of the judgment would be to restrain the Government from acting, or to compel it to act") (internal quotations omitted). Here, the purpose of the injunction and other orders Palomar Pomerado seeks is to "restrain the Government" from reducing the Medi-Cal payment rates charged by Palomar Pomerado to the discounted rates offered patients who pay privately or who are privately insured. The result Palomar Pomerado seeks would "interfere with the public administration." As such, Palomar Pomerado's action falls under the category of actions against state officials that are in fact actions against the state.

Ex parte Young, 209 U.S. 123, 28 S.Ct. 441, 52 L.Ed. 714 (1908), provides an exception to the "general rule" set out above. Assuming that Palomar Pomerado could establish standing, the fact that it is suing defendants in their individual capacities would allow it to invoke *Ex parte Young* to circumvent the state's Eleventh Amendment immunity. *See id.* at 155-56, 28 S.Ct. 441. But *Ex parte Young* does not provide Palomar Pomerado with standing to sue in federal court. *Young* only provides "a narrow exception to *Eleventh Amendment immunity* for certain suits seeking declaratory and injunctive relief against unconstitutional actions taken by state officers in their

official capacities." *Rounds v. Oregon State Bd. of Higher Educ.*, 166 F.3d 1032, 1036 (9th Cir.1999) (emphasis added); *see also Doe v. Lawrence Livermore Nat'l Lab.*, 131 F.3d 836, 839 (9th Cir.1997) (*Young* "provides a narrow . . . exception to *Eleventh Amendment immunity*") (emphasis added).

III.

Palomar Pomerado is a political subdivision of the State of California. As such, it lacks standing to bring an action against the state in federal court – at least to the extent that its action challenges the validity of state regulations on due process and Supremacy Clause grounds. *See South Lake Tahoe*, 625 F.2d at 233-34 ("Because all of its claims are based on the [federal] Constitution, the City's challenge was properly dismissed [on standing grounds].").

Because Palomar Pomerado lacks standing, the federal courts are without jurisdiction over this action. *See id.* at 233. Accordingly, this appeal is DISMISSED, and the decision of the district court is VACATED.

MICHAEL DALY HAWKINS, Circuit Judge, concurring:

The majority is undoubtedly correct in applying current circuit law, especially the way in which *City of South Lake Tahoe v. California Tahoe Reg'l Planning Agency*, 625 F.2d 231 (9th Cir.1980), has been subsequently interpreted. *See Burbank-Glendale-Pasadena Airport Auth. v. City of Burbank*, 136 F.3d 1360 (9th Cir.1998). Because the current law in this circuit calls for a ban on *any* constitutional

challenge by a political subdivision against its "parent state" – an interpretation at odds with at least three other circuits – I believe our en banc court should take another look at *South Lake Tahoe* and its progeny.

South Lake Tahoe cited a long list of cases to support the statement that "[a] City may not challenge [a state agency's] plans and ordinances on constitutional grounds." However, none of the cited cases involved a Supremacy Clause challenge (at issue in *South Lake Tahoe*); rather, they addressed Fourteenth Amendment or Contract Clause challenges. *Burbank-Glendale-Pasadena Airport Authority v. City of Burbank*, 136 F.3d 1360 (9th Cir.1998), simply relied on *South Lake Tahoe*. We have thus never satisfactorily stated our rationale for including all constitutional challenges within the ban.

On the other hand, circuits that have rejected a "per se" rule against all constitutional challenges have provided convincing reasons for doing so. In *Rogers v. Brockette*, 588 F.2d 1057 (5th Cir.1979), the Fifth Circuit traced the history of cases denying standing to political subdivisions that sued their parent states. The court focussed on the foundational Supreme Court cases which dealt with municipalities' rights under the Contract Clause, the Just Compensation Clause, and Equal Protection. *See, e.g., Williams v. Mayor & City Council of Baltimore*, 289 U.S. 36, 53 S.Ct. 431, 77 L.Ed. 1015 (1933); *Trenton v. New Jersey*, 262 U.S. 182, 43 S.Ct. 534, 67 L.Ed. 937 (1923); *Hunter v. City of Pittsburgh*, 207 U.S. 161, 28 S.Ct. 40, 52 L.Ed. 151 (1907).

In these cases, the Court's primary concern was that a state whose relations with its municipalities were

bound by the broad constitutional principles that govern its relations with private parties would be practically unable to legislate. *See Rogers,* 588 F.2d at 1068-69. Although the cases spoke in terms of standing, they are more accurately described as "substantive holdings that the Constitution does not interfere in states' internal political organization." *Id.* at 1069 (noting that "standing" had a different meaning when *Hunter,* etc. were decided). Not every constitutional provision presents the danger of such interference. *Rogers* concluded that where a municipality alleged a violation of federal law under the Supremacy Clause, it was Congress, not the Constitution, that was interfering in the states' internal political organization.

The Tenth Circuit has also interpreted the early Supreme Court cases more narrowly, describing them as "stand[ing] only for the limited proposition that a municipality may not bring a constitutional challenge against its creating state when the constitutional provision that supplies the basis for the complaint was written to protect individual rights, as opposed to collective or structural rights." *Branson Sch. Dist. RE-82 v. Romer,* 161 F.3d 619, 628 (10th Cir.1998). Challenges based on the latter category of rights, the Tenth Circuit reasoned, do not raise the spectre of the "chaos" of lawsuits generated by "mere disagreement by a political subdivision with the policies of its parent state." *Id.* at 630. The *Branson* court thus allowed a school district to invoke the Supremacy Clause against its parent state for violation of a federal law.

Indeed, the Supreme Court has itself indicated that its rule does not apply equally to all constitutional challenges. In *Gomillion v. Lightfoot*, 364 U.S. 339, 81 S.Ct. 125, 5 L.Ed.2d 110 (1960), a case that did not directly present the issue of a municipality's standing to sue, the Court had opportunity to interpret the *Hunter* line of cases, and stated:

> [A] correct reading of the seemingly unconfined dicta of Hunter and kindred cases is not that the State has plenary power to manipulate in every conceivable way, for every conceivable purpose, the affairs of its municipal corporations, but rather that the State's authority is unrestrained *by the particular prohibitions of the Constitution considered in those cases.*

Gomillion, 364 U.S. at 344, 81 S.Ct. 125 (emphasis added). When the Supreme Court denied certiorari in *South Lake Tahoe*, Justice White dissented on the grounds that a per se rule was inconsistent with *Board of Education v. Allen*, 392 U.S. 236, 88 S.Ct. 1923, 20 L.Ed.2d 1060 (1968), a case in which a local board of education challenged the constitutionality of a state statute on First Amendment grounds. *See City of South Lake Tahoe v. California Tahoe Reg'l Planning Agency*, 449 U.S. 1039, 1042, 101 S.Ct. 619, 66 L.Ed.2d 502 (1980) (White, J., dissenting from denial of certiorari).

The Fifth and Tenth Circuits have noted another apparent limitation on the breadth of the rule, this one stemming from the nature of the political subdivision rather than the nature of the constitutional provision. In one of its earliest cases on the subject, the Supreme Court made the following observation:

> It will be observed that, in describing the absolute power of the state over the property of municipal corporations, we have not extended it beyond the property held and used for governmental purposes. Such corporations are sometimes authorized to hold and do hold property for the same purposes that property is held by private corporations or individuals. The distinction between property owned by municipal corporations in their public and governmental capacity and that owned by them in their private capacity, though difficult to determine, has been approved by many of the state courts, and it has been held that, as to the latter class of property, the legislature is not omnipotent.

Hunter at 179, 28 S.Ct. 40 (*quoted in Rogers*, 588 F.2d at 1069). Relatedly, in *Lassen v. Arizona ex rel. Arizona Highway Dep't*, 385 U.S. 458, 87 S.Ct. 584, 17 L.Ed.2d 515 (1967), the Court stated, "This action is in form and substance a controversy between two agencies of the State of Arizona. . . . We have nonetheless concluded that this is a case with which we may properly deal. The Land Commissioner is apparently a substantially independent state officer, appointed for a term of years and removable only for cause. He is essentially the trustee of the trust at issue here, with custody of the trust lands." *Id.* at 460 n. 1, 87 S.Ct. 584 (*quoted in Branson*, 161 F.3d at 629). In short, the Court has recognized a difference between political subdivisions acting in their governmental roles and political subdivisions acting in a private or substantially independent capacity. The latter may be able to sue the state in situations where the former could not.

The Fifth and Tenth Circuits are joined by the Eleventh Circuit in expressly rejecting a per se rule. *See United*

States v. Alabama, 791 F.2d 1450, 1455 (11th Cir.1986). Other circuits have suggested, without holding, that they do not favor such a rule. *See City of Charleston v. Public Serv. Comm.*, 57 F.3d 385, 389-90 (4th Cir.1995) (noting that a political subdivision's standing regarding a non-Fourteenth Amendment claim was "unclear" and proceeding to resolve the issue on the merits); *South Macomb Disposal Auth. v. Township of Washington*, 790 F.2d 500, 504 (6th Cir.1986) (noting that "[t]here may be occasions in which a political subdivision is not prevented, by virtue of its status as a subdivision of the state, from challenging the constitutionality of state legislation"). Certainly the Ninth Circuit is alone in having barred Supremacy Clause challenges by political subdivisions against their parent states.

The existence of a contrary view in other circuits does not automatically suggest a need to reexamine our own position. However, where the other circuits' view is well and thoroughly reasoned, we should at least satisfy ourselves that our position is grounded in an equally solid rationale. I therefore suggest that we revisit *South Lake Tahoe's* holding en banc.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

PALOMAR POMERADO HEALTH SYSTEM, a Health Care District,

Plaintiff,

v.

S. KIMBERLY BELSHE, Director of the California Department of Health Services; DIETER MERKLE; and CURTIS COTTON,

Defendants.

CIV-S-97-0294 DFL GGH

MEMORANDUM OF OPINION AND ORDER

(Filed March 30, 1998)

This case arises out of a State audit of plaintiff's Medicaid billing practices. Plaintiff Palomar Pomerado Health System ("Palomar Pomerado") asserts that defendant Department of Health Services ("DHS") violated the Boren Amendment by using the State's regulatory prohibition on discriminatory billing to reduce plaintiff's Medi-Cal reimbursement rate and recoup $2.8 billion of alleged overpayments. Plaintiff requests an injunction to enjoin DHS from reducing reimbursement to the discounted charges made to private-pay patients, and an order declaring that plaintiff is entitled to continue to provide a prompt-pay discount to its private-pay patients without jeopardizing its right to receive Medi-Cal payments at the higher rates established by the Medi-Cal

program under the governing federal Medicaid law and regulations.

Plaintiff and defendants make cross-motions for summary judgment. The single question of law to be decided is whether the Boren Amendment preempts state regulations implementing the discriminatory billing policy.

I.

Palomar Pomerado Health System ("Palomar Pomerado") provides, among other services, long-term health care service at two "distinct part" skilled nursing facilities ("DP/NF")[1] in San Diego County, California – the Palomar Continuing Care Center and the Villa Pomerado. Plaintiff provides services to privately insured patients, to Medi-Cal patients, and to patients who pay for services on their own ("private-pay patients"). The two facilities bill patients in a similar manner.

Until April 1994, patients were billed based on the level of care they required. In April 1994, Palomar Pomerado introduced a flat-rate system based only on the type of room the patient occupied. At the same time, Palomar Pomerado introduced a prompt-pay discount policy for private-pay patients. Patients who paid their bills within 30 days and had paid an initial deposit were to be given a 50% discount on services; with the discount,

---

[1] A distinct part facility operates as a distinct part of a hospital as opposed to a freestanding nursing facility which is not part of a hospital.

most private-pay patients are billed at $100 per day.[2] Palomar Pomerado offers this discount both to private-pay patients and to patients who are privately insured. Medi-Cal is not offered the discount. The discount policy has changed numerous times since its commencement.[3] The current discounted rate is $133.00 at Palomar Continuing Care Center and $120.00 per day at Villa Pomerado. Approximately 8% of patients at Palomar Continuing Care Center, and 40% of the patients at Villa Pomerado, currently receive the discount.

The Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A), requires the state to reimburse providers such as Palomar Pomerado at a rate that is "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities."[4] This requirement is implemented by 22 C.C.R. § 51511(a)(2): "For nursing facilities that are distinct parts of acute care hospitals, if such facilities are not state operated, the per diem reimbursement rate shall be the lesser of the facility's costs as projected by DHS or $214.90." The rates paid by DHS in past years for Medi-Cal beneficiaries under this rate-setting mechanism significantly exceeded the discounted rates offered to private-pay patients.[5]

---

[2] Approximately 8% of patients at Palomar Continuing Care Center, and 40% of the patients at Villa Pomerado, currently receive the discount. (Reid Supp. Decl., ¶ 4).

[3] *See* Cotton Decl., Exs. K, L, M, P).

[4] Subsequent to the filing of this action, the Boren Amendment was abrogated. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711(a), 111 Stat. 251, 507-08 (1997).

[5] To illustrate the disparity between the $100 a day discount rate and audited per day costs, the audited per day costs in 1994

DHS annually audits skilled nursing facilities and other providers. California regulations prohibit a provider from seeking reimbursement from DHS for services provided to a Medi-Cal beneficiary "in any amount greater or higher than the usual fee charged by the provider to the general public for the same service." 22 C.C.R. § 51480(a). In its audit for the fiscal year ending June 30, 1994, DHS concluded that the "usual fee" Palomar Pomerado charged members of the public was $100 a day, the discounted charge. Using this rate, DHS concluded that it had been overcharged by approximately $558,000 for the period beginning April 1, 1994 and ending June 30, 1994. DHS then began a recoupment action. Plaintiff has filed an administrative appeal.

Palomar Pomerado contends that the discount was introduced as a matter of grace to relieve the burden on private-pay patients,[6] and that DHS may not claim the discounted rate because any reduction from the rate established by 22 C.C.R. § 51511(a)(2) not based on its audited costs necessarily violates the Boren Amendment. Defendants continue to enforce 22 C.C.R. § 51480(a) against plaintiff, and recently assessed over $50 million in civil penalties against plaintiff for the period July 1, 1989 to June 30, 1995.

---

after appeal for the two facilities was $159.19 and $152.42. The 1995 figures were $132.84 and $132.00. (Cotton Decl., ¶¶ 21-22).

[6] Palomar Pomerado offers no proof for its earlier position that the $100 a day discounted rate is below its costs.

II.

Defendants contend that the court should abstain from exercising jurisdiction under either *Burford v. Sun Oil Co.*, 319 U.S. 315, 63 S. Ct. 1098 (1943) or *Railroad Comm'n of Texas v. Pullman Co.*, 312 U.S. 496, 61 S. Ct. 643 (1941). Plaintiffs contend that abstention is improper because defendants should have raised the issue at an earlier stage of the proceeding, and because the state courts will not provide an adequate remedy.

A. *Burford* Abstention

The Supreme Court set forth the requirements of the *Burford* abstention doctrine in *New Orleans Pub. Serv., Inc. v. Council of New Orleans*, 491 U.S. 350, 361, 109 S. Ct. 2506, 2514 (1989) (citation omitted):

> Where timely and adequate state-court review is available, a federal court sitting in equity must decline to interfere with the proceedings or orders of state administrative agencies: (1) when there are "difficult questions of state law bearing on policy problems of substantial public import whose importance transcends the result in the case at bar"; or (2) where the "exercise of federal review of the question in a case and in similar cases would be disruptive of state efforts to establish a coherent policy with respect to a matter of substantial public concern."

The Ninth Circuit generally limits application of the *Burford* abstention doctrine to situations where certain factors apply: "(1) that the state has concentrated suits involving the local issue in a particular court; (2) the

federal issues are not easily separable from the complicated state law issues with which the state courts may have special competence; and (3) that federal review might disrupt state efforts to establish a coherent policy." *Tucker v. First Maryland Sav. & Loan, Inc.*, 942 F.2d 1401, 1405 (9th Cir. 1991). A court may abstain under *Burford* only in cases presenting extraordinary circumstances. *Quackenbush v. Allstate Ins. Co.*, ___ U.S. ___, 116 S. Ct. 1712, 1727 (1996).

Abstention is improper if federal issues predominate or may be controlling. *NOPSI*, 491 U.S. at 362, 109 S. Ct. at 2515. Defendants cite a number of examples where district courts have abstained from exercising jurisdiction in Medicaid rate cases. The key characteristic of these examples is that the court characterized the provider's challenge not as a facial claim of preemption by federal law, but as the state agency's misapplication of its lawful authority or its failure to consider or properly weigh the relevant factors as required by state law in a particular case. *See St. Michael Hosp. v. Thompson*, 725 F. Supp. 1038, 1044 (W.D. Wis. 1989) (abstention proper where provider alleged that state agency failed to provide fair reimbursement because of use of non-representative base year); *Osteopathic Hosp. Founders Ass'n, Inc. v. Splinter*, 955 F. Supp. 1351 (N.D. Okla. 1996) (abstention proper in provider's non-systematic challenge to recoupment by state agency based on reporting of Medicaid patient days); *Heartland Hosp. v. Stangler*, 792 F. Supp. 670, 672 (W.D. Mo. 1992) (abstention proper in "as applied" challenge by inpatient psychiatric hospital to per diem cap).

The threshold question then is whether the plaintiff's challenge is a facial claim of federal preemption or if it is

more properly characterized as an "as applied" challenge to the state agency's interpretation of state regulations. The central legal question to be decided is whether application of the state's ban on discriminatory billing, limiting reimbursement to the "usual charges" made to the general public, violates the Boren Amendment.[7] Because the federal question predominates, the court declines to abstain under *Burford*.

B. *Pullman* Abstention

The Ninth Circuit has stated that "[t]he *Pullman* abstention doctrine is a 'narrow exception to the district court's duty to decide cases properly before it.' " *Cedar Shake and Shingle Bureau v. City of Los Angeles*, 997 F.2d 620, 622 (9th Cir. 1993) (quoting *Kollsman v. City of Los Angeles*, 737 F.2d 830, 833 (9th Cir. 1984), *cert. denied*, 469 U.S. 1211, 105 S. Ct. 1179 (1985)). *Pullman* abstention is appropriate where:

> (1) The complaint touches a sensitive area of social policy upon which the federal courts ought not to enter unless no alternative to its adjudication is open.
>
> (2) Such constitutional adjudication plainly can be avoided if a definitive ruling of the state issue would terminate the controversy.

---

[7] Plaintiff is not asking this court to decide whether the rate-setting rules, as applied, result in an inadequate reimbursement payment to this particular provider. The court does not reach the question whether abstention would be appropriate in an "as applied" challenge to the discriminatory billing rules.

(3) The possibly determinative issue of state law is doubtful.

Sinclair Oil Corp. v. County of Santa Barbara, 96 F.3d 401, 409 (9th Cir. 1996) (citations omitted).

Defendants cite no persuasive authority supporting the proposition that *Pullman* abstention is proper in Medicaid cases.[8] Moreover, the case as presented is a straightforward question of statutory interpretation involving a federal statute. Accordingly, the court declines to abstain under the *Pullman* abstention doctrine.

III.

Defendants contend that the individual defendants named in this action are extraneous and redundant, and should be dismissed from the action. Defendants cite two cases in support of this argument, but both pertain only to *Monell* actions against local government entities, not suits against state agencies. *Kentucky v. Graham*, 473 U.S. 159, 167 n.14, 105 S. Ct. 3099, 3016 n.14 (1985); *Luke v. Abbott*, 954 F. Supp. 202 (C.D. Cal. 1997). The defendant entity in the present case is state agency, not a local government entity, and therefore is not subject to suit in federal court under 42 U.S.C. § 1983. Defendants' motion for summary judgment is DENIED as to dismissal of the auditor defendants.

---

[8] The first case cited by defendants, *Trainor v. Hernandez*, 431 U.S. 434, 97 S. Ct. 1911 (1977), is a *Younger* abstention case. The other two cases – *St. Joseph Hosp. v. Electronic Data Systems*, 573 F. Supp. 443 (S.D. Tex. 1983), and *Arden House, Inc. v. Heintz*, 612 F. Supp. 81 (D.C. Conn. 1985) (citing *St. Joseph Hosp.*) – are actually *Burford* abstention cases.

IV.

Whether a state's Medicaid plan procedurally and substantively complies with federal Medicaid laws is a question of law subject to *de novo* review. *AMISUB (PSL), Inc. v. Colorado Dep't of Social Servs.*, 879 F.2d 789, 796 (10th Cir. 1989), *cert. denied*, 496 U.S. 935, 110 S. Ct. 3212 (1990). A federal court should review *de novo* a state agency's interpretation of a federal statute. *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), *pet. for cert. filed*, 65 USLW 3755 (April 28, 1997); *Turner v. Perales*, 869 F.2d 140, 141 (2d Cir. 1989); *Lewis v. Hegstrom*, 767 F.2d 1371, 1376 (9th Cir. 1985). Federal courts are not required to give deference to a state's determination whether state law and regulations are consistent with the governing federal law. *Belshe*, 103 F.3d at 1496.

Plaintiff frames the issue before the court as a simple legal question whether federal law precludes California from using its discriminatory billing rules as part of its Boren Amendment rate-setting mechanism. The court need not defer to the Department in resolving this question.

A. Statutory and Regulatory Framework

1. Federal Laws

The Boren Amendment,[9] repealed effective October 1, 1997, requires that states provide reimbursement rates to nursing facility services providers such as Palomar Pomerado

---

[9] 42 U.S.C. § 1396a(a)(13)(A)

> which the State finds, and makes assurances satisfactory to the Secretary, are *reasonable and adequate* to meet the costs which must be incurred by *efficiently and economically operated facilities* in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality. . . .

The Boren Amendment was enacted to achieve two goals: "first, that the state set their own reimbursement rates without stifling and expensive federal oversight of the methodology used; and, second, that Medicaid expenses be reduced by allowing the states to develop payment systems that would encourage efficiency." *Colorado Health Care Ass'n v. Colorado Dep't of Soc. Servs.*, 842 F.2d 1158, 1165 (10th Cir. 1988). Courts reviewing the legislative history have found that "states are to be free to experiment with methods and standards for payment that would be simpler and less expensive than the complex Medicare reasonable cost formula." *See Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 392 (5th Cir. 1980).

States are given wide latitude to determine the range of permissible reimbursement rates. The Boren Amendment does not definitively establish a minimum reimbursement rate. Substantive compliance with the Boren Amendment requires only that the state provide a reimbursement rate that reasonably and adequately reimburses at least some efficiently and economically operated providers within the state. *See AMISUB*, 879 F.2d at 799 (disallowing use of budget adjustment factor where

unrebutted evidence showed "no state hospital, no matter how efficiently and economically operated, is reasonably and adequately reimbursed").

There are two federal regulations establishing upper limits to Boren Amendment reimbursement rates. One upper limit is an aggregate limit for all nursing facilities in the state: "[A]ggregate payments by an agency to each group of health care facilities (that is, hospitals, nursing facilities . . .) may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles." 42 C.F.R. § 447.272 (a). A second upper limit restricts reimbursement for inpatient hospital services to the provider's "customary charges," but this section does not apply to long-term care service providers like Palomar Pomerado. *See* 42 C.F.R. § 447.271 (a).

2. California Laws and Regulations

The California State Medicaid Plan provides the required assurances to the federal government that its rate-setting mechanism satisfies the requirements of the Boren Amendment. The State Plan incorporates the two rate-setting devices that are central to the audit dispute, 22 C.C.R. § 51511 (a) (2) and the regulation prohibiting discriminatory billing, 22 C.C.R. § 51480 (a). DHS asserts that both apply to Palomar Pomerado, while plaintiff asserts that the latter cannot be applied consistently with the former and thus violates the Boren Amendment.

Section 51511 (a) (2) establishes that the per diem reimbursement rate, for the period from August 1, 1996 to July 31, 1997, for non-state operated distinct part nursing

facilities "shall be the lesser of the facility's costs as projected by the Department or $214.90." The maximum allowable reimbursement, $214.90, represents the median per diem cost of providing DP/NF services. The facility's projected costs for routine services are calculated by dividing its total audited expenses for routine services (for all patients) by the number of days of routine services (also for all patients). (Reid Supp. Decl., ¶ 3). The auditing process is governed by state law and regulations. *See* Cal. Welf. & Inst. Code § 14170(b); 22 C.C.R. §§ 51021-51024.

The State Plan also limits reimbursement rates under the billing regulations that forbid providers from charging the Medicaid program at a higher rate than normal:

"Notwithstanding any other provisions of these regulations, the reimbursement rate shall be limited to the usual charges made to the general public, not to exceed the maximum reimbursement rates set forth by this plan." (Pl.'s Ex. B, ¶ I.G.). Section 51480 provides that "No provider shall bill or submit a claim for reimbursement for the rendering of health care services to a Medi-Cal beneficiary in any amount greater or higher than the usual fee charged by the provider to the general public for the same service." 22 C.C.R. § 51480(a). Section 51501 similarly provides that "Notwithstanding any other provisions of these regulations, no provider shall charge for any service or any article more than would have been charged for the same service or article to other purchasers of comparable services or articles under comparable

circumstances." 22 C.C.R. § 51501 (a).[10] The state may recoup overpayments resulting from discriminatory billing under 22 C.C.R. § 51458.1 (a): "The Department shall recover overpayments to providers including, but not limited to, payments determined to be: . . . (2) In excess of the amounts usually charged by a provider."

B. Consistency With the Boren Amendment

Palomar Pomerado contends that the State's nondiscrimination regulations violate the Boren Amendment because federal Medicaid law does not authorize limiting reimbursement based on usual charges to the general public, and DHS is prohibited from reducing the rates set forth in 22 C.C.R. § 51511 because of the "efficiency and economy" standard. It is a question of first impression whether the Boren Amendment permits a state to limit reimbursement rates paid to a long-term health care services provider on a "usual charge"-related basis.

The only express upper limit set by federal Medicaid law applicable to long-term care providers like Palomar Pomerado is the aggregate limitation in 42 C.F.R. § 447.272 (a). DHS does not dispute that the upper limit in 42 C.F.R. § 447.271 (a), based on "usual charges to the general public," applies only to inpatient services provider, and not to long-term service providers such as Palomar Pomerado.

---

[10] 22 C.C.R. § 51501 (a) is construed consistently with § 51480 to limit billing to the "usual" or "customary" charge for the same service. (Def.'s Supplemental Letter Brief).

That the section is not directly applicable, however, does not diminish its significance. Reimbursement rates for inpatient services providers are governed by the Boren Amendment. *See* 42 U.S.C. § 1396a (a) (13) (A). The simple fact is that federal Medicaid law expressly permits limitation of Boren Amendment reimbursal rates on a "usual charge"-related basis, although not for all classes of providers. By adopting section 447.271 (a), the Secretary of the Health Care Financing Administration necessarily found that limiting a provider's reimbursal rate to the "usual charges to the general public" is consistent with the Boren Amendment, a position that is consistent with common sense as well as the broad language of the Boren Amendment.

The Boren Amendment requires no more than findings and assurances that reimbursement rates provided to an efficiently and economically operator are "reasonable and adequate." The State need not fix a single rate or a percentage of costs for Medicaid reimbursement: "Medicaid payment rates are 'reasonable and adequate' . . . if they fall within a 'zone or range of reasonableness.' " *Folden*, 744 F. Supp. at 1529 (quoting *Colorado Health Care Ass'n*, 842 F.2d at 1167 (collecting cases with similar holdings)). A determination that one rate falls within the zone of reasonableness does not mean that all other rates are unreasonable. *See Folden*, 744 F. Supp. at 1529.

Relying on the assumption that costs and charges are related – an eminently sensible assumption – the State, through its regulations forbidding discriminatory billing, has developed a simple and inexpensive means to lower the costs of health care – precisely the type of mechanism that the Boren Amendment was designed to encourage.

To find that federal law prohibits what it does not expressly authorize would defeat the very intent of the Boren Amendment, to confer greater discretion on the states to develop flexible methods of controlling health costs. The court finds, consistent with HCFA's regulation at 42 C.F.R. § 447.271 (a), that a "usual charge" based reimbursement cap is not in conflict with the Boren Amendment but represents a reasonable policy choice. *See Physicians & Surgeons Labs., Inc. v. Department of Health Servs.*, 6 Cal. App. 4th 968, 8 Cal. Rptr. 2d 565 (1992).

Accordingly, defendants' motion for summary judgment is GRANTED.

C. Due Process

Palomar Pomerado also contends that DHS applies the "usual charge" billing regulations in an arbitrary and capricious manner. Plaintiff argues that DHS has no authority to regulate plaintiff's behavior with regard to private-pay patients, that extending discounts to private-pay patients reduces the burden of supporting health care on the taxpayers, and that eliminating the discount would ultimately result in an increase in its facilities' average allowable daily costs. Whatever the strengths of these contentions as a matter of policy, they do not demonstrate such arbitrary conduct as to support the claim of a due process violation by defendants.

Furthermore, DHS has presented uncontroverted evidence that Palomar Pomerado has been on notice of the potential applicability of the discriminatory billing rules since 1987 when Palomar Convalescent Center was first

approved as a DP/NF provider.[11] Moreover, the applicability of discriminatory billing rules is set forth in the State Medicaid Plan. The regulations were not applied retroactively.

V.

For the reasons stated above, defendants' motion for summary judgment is GRANTED.

IT IS SO ORDERED.

Dated: 26 March 1998.

/s/ David F. Levi
DAVID F. LEVI
United States District Judge

---

[11] *See* Cotton Decl., ¶ 4 & Ex. D.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

JUDGMENT IN A CIVIL CASE

(Filed Mar. 30, 1998)

Palomar Pomerado Health System

v.

CASE NUMBER :
CIV S-97-294 DFL GGH

S Kimberly Belshie

XX – **Decision by the Court.** This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

THAT JUDGMENT IS HEREBY ENTERED IN ACCORDANCE WITH THE COURT'S ORDER OF MARCH 30, 1998.

Jack L. Wagner,
Clerk of the Court

By: /s/ George Miyasato
G Miyasato, Deputy Clerk

ENTERED: March 30, 1998

HOOPER, LUNDY & BOOKMAN, INC.
PATRIC HOOPER (State Bar No. 57343)
1875 Century Park East, Suite 1600
Los Angeles, California 90067-2799

Tel: (310) 551-8111
Fax: (310) 551-8181

Attorneys for Petitioner
PALOMAR POMERADO HEALTH SYSTEM

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SACRAMENTO

PALOMAR POMERADO HEALTH SYSTEM, Petitioner, v. DIRECTOR OF THE STATE DEPARTMENT OF HEALTH SERVICES, STATE OF CALIFORNIA, Respondent.	Case No. 99CS01351 PETITION FOR WRIT OF MANDATE CODE OF CIVIL PROCEDURE § 1094.5 (Filed Jul. 7, 1999)

Petitioner, Palomar Pomerado Health System, alleges as follows:

INTRODUCTION

1. Among other health care services, Palomar Pomerado Health System ("Palomar Pomerado") provides long-term health care services at two "distinct part" skilled nursing facilities of its two acute care hospitals in the County of San Diego. While most of the long-term

care patients to whom Palomar Pomerado provides services are insured through Medicare, Medi-Cal, or some form of private health insurance, some patients requiring long-term care services at the two facilities have no health insurance coverage for long-term care services, and are among the millions of Americans who are care services out of their own limited financial resources. To help alleviate the substantial financial burden on such patients, Palomar Pomerado has provided self-pay patients with discounts off Palomar Pomerado's usual charges, which enable the patients to receive long-term care services at rates less than the rates received for services furnished to patients insured by public and private third-party payors, including the Medi-Cal program. This practice often also postpones the patients becoming Medi-Cal patients, which actually reduces Medi-Cal expenditures.

2. Even though the Director of the State Department of Health Services ("Department") has confirmed that the governing Medi-Cal regulations do *not* permit Palomar Pomerado to offer or furnish similar discounts for services furnished to Medi-Cal patients, the Department has nevertheless concluded that Palomar Pomerado's billing practices constituted "discriminatory billing." As a result, the Department has concluded that it may recoup millions of dollars of past Medi-Cal payments to reflect the difference between the discounted rate received by Palomar Pomerado for each day of service furnished to a self-pay patient, and the Medi-Cal rate actually paid to Palomar Pomerado for each day of service furnished to Medi-Cal patients. Palomar Pomerado contends that the

Department's recoupment action violates federal Medicaid state law and regulations, law and regulations, is arbitrary and capricious, and was untimely commenced and unauthorized.

PARTIES

3. Palomar Pomerado is organized as a health care district under California Health and Safety Code Sections 32000 *et. seq.* Palomar Pomerado operates Palomar Medical Center and Pomerado Hospital, two general acute care hospitals located in San Diego County. As indicated above, each hospital owns and operates a separately licensed and separately Medi-Cal certified distinct part nursing facility known respectively as "Palomar Continuing Care Center" and "Villa Pomerado."

4. Respondent, Director of the Department, is the head of the single state Medicaid agency charged with administering California's Medicaid program, known as "Medi-Cal." Welf. & Inst. Code §§ 14000 *et. seq.*, and 22 C.C.R. §§ 50000 *et. seq.*

THE MEDICAID PROGRAM

5. The Medicaid program, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.*, 42 C.F.R. §§ 430.0 *et seq.*, is the federal/state health insurance program for the poor. Payment for services furnished to Medicaid beneficiaries is made directly to the health care entities and persons that furnish the service, *i.e.*, "providers," such as Palomar Pomerado. 42 C.F.R. § 447.251.

6. Among the health care services required to be furnished to Medicaid patients under a state Medicaid plan are nursing facility services, which are long-term care services, 42 U.S.C. § 1396d(a)(4)(A) and 42 C.F.R. § 447.251. Such services are to be distinguished from inpatient acute care hospital services, which are typically short-term acute care services. Long-term care services are provided in "distinct parts" of hospitals or in free-standing nursing facilities.

7. Each state's Medicaid program must be administered by a single state agency. 42 U.S.C. § 1396a(a)(5). As indicated above, the Department is the single state agency designated to administer California's Medicaid program – "Medi-Cal." While a state's participation in Medicaid is optional, if the state chooses to participate, it is bound by the federal Medicaid laws and regulations.

8. Originally, federal Medicaid law required state Medicaid agencies to reimburse providers of inpatient hospital services and long-term care services using Medicare reasonable cost principles. (Medicare is the federal health insurance program for the aged and the disabled. 42 U.S.C. §§ 1395 *et. seq.*) Those principles limited payment to the reasonable costs actually incurred by providers to furnish services to Medicare and Medicaid patients.

9. In 1972, Congress amended the Medicare and Medicaid laws to impose a limit on Medicare and Medicaid payment for *hospital* services such that payment could not exceed a provider's "customary charges" to the general public for hospital services. The 1972 amendment

imposed the customary charge limit *only* on *hospital* services. It did not impose the limit on long-term care services, such as those here. 42 U.S.C. § 1396b(i)(3).

10. In 1980, Congress amended the federal Medicaid statute again to allow state Medicaid agencies to depart from the *Medicare* reasonable cost payment methodology for paying for long-term care services. Under the 1980 legislation, known as the "Boren Amendment," state Medicaid agencies were required to make findings and submit assurances to the federal government confirming that the state Medicaid payment rates for long-term care services were reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated nursing facilities. 42 U.S.C. § 1396a(a)(13). In 1981, Congress amended the Medicaid Act to expand the provisions of the Boren Amendment to payment for inpatient hospital services. *See* Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, Section 2173, implemented at 42 U.S.C. § 1396a(a)(13)(A).

11. In 1997, the Medicaid Act was amended again to replace the Boren Amendment and its 1981 sequel establishing the efficiency and economy standard with notice and comment requirements for the establishment of Medicaid payment rates for inpatient hospital services and long-term care services. *See* Balanced Budget Act of 1997, Public Law 105-33, 111 Stat. 251, Section 4711 (1997), *codified* at 42 U.S.C. § 1396a(a)(13)(A).

12. Notwithstanding the 1980, 1981, and 1997 amendments to the Medicare and Medicaid Acts, the 1972 customary charge payment limit, referred to in Paragraph 9, was not amended and continued to apply expressly

only to Medicaid payment for *hospital* services. Neither the Medicaid statute nor the Medicaid regulations expressly impose a customary charge limit on Medicaid payment for long-term care services. Instead, the customary charge limit was, and continues to be, expressly applicable only to Medicaid payment for hospital services. *See* 42 U.S.C. § 1396b(i)(3) and 42 C.F.R. § 447.271(a).

MEDI-CAL PAYMENT RATES FOR LONG-TERM CARE SERVICES

13. Because of the material difference in the costs of furnishing long-term care services in a distinct part unit of a hospital and the costs of providing long-term care services in a free-standing nursing facility, the Department has established separate Medi-Cal payment rates for long-term care services provided in the two settings. *See* California Welf. & Inst. Code § 14091.21. As required by the federal Medicaid law, the Department expressly intends the Medi-Cal payment rates for long-term care services furnished in distinct part nursing facilities of hospitals to reimburse providers at a rate that is reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities.

14. To implement this intent, the Department promulgated 22 C.C.R. Sections 51546(g) and 51511(a)(2), which require long-term care services furnished in a distinct part nursing facility of a hospital to be paid at a "per diem" rate equal to the lesser of the facility's allowable costs per day, as projected by the Department, or the median of the cost per day for all distinct part nursing

facilities in the state, which during much of the period at issue was approximately $200.00 per day. The per diem Medi-Cal payment rate for distinct part nursing facility services is intended to cover a "package" of services, including but not limited to, room and board and certain ancillary services. 22 C.C.R. § 51511(b).

15. To determine the allowable cost per day for each provider of distinct part nursing facility services and the resulting median rate for all providers of distinct part nursing facility services, the Department audits Medi-Cal cost reports submitted annually by providers of distinct part nursing facility services. Welf & Inst. Code § 14170. The Department arrays the allowable cost per day of each distinct part nursing facility from highest to lowest to determine the median, *i.e.*, the 50th percentile, which represents the "upper limit" on the range of rates the Department deems to be reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers of long-term care services.

16. As indicated above, under the governing Medi-Cal regulation, Section 51511(a)(2), a distinct part nursing facility provider of long-term care services was required to be reimbursed at a Medi-Cal rate equal to the "lesser of the facility's costs as projected by the Department or $214.90 per day." Thus, if a provider's projected allowable costs per day are less than the median rate for providers of distinct part nursing facilities, $214.90, the Department will pay the provider at the rate determined by the projected facility-specific allowable cost per day. If there are greater than $214.90 per day, the Department will pay only $214.90 per day. This sum is paid the provider even if the provider's usual and customary

charge per day for long-term care services exceeds the Medi-Cal per diem rate.

17. Providers submit bills for Medi-Cal services to the Medi-Cal fiscal intermediary. The bills contain the rates for routine and ancillary long-term care services provided to each Medi-Cal patient.

THE STATE IMPOSED USUAL/CUSTOMARY CHARGE LIMIT

18. Notwithstanding the above method for determining the Medi-Cal payment rate necessary for providers to meet the costs of efficiently and economically operating, the Department has included a provision in its Medicaid State Plan and in certain Medi-Cal regulations, other than 22 C.C.R. Sections 51546(g) and 51511 (the specific regulations establishing Medi-Cal long-term care rates), which purportedly limits Medi-Cal payment for long-term care services "to the usual charges made to the general public, not to exceed the maximum reimbursement rate" set forth in the State Medicaid Plan. Similar language is contained in 22 C.C.R. Sections 51480 and 51501, which prohibit a provider from submitting a claim for reimbursement for the rendering of health care services to a Medi-Cal beneficiary in an amount higher than the "usual fee" charged by the provider to the general public for the same services. *See also* 22 C.C.R. § 51458.1(a)(2).

THE MEDI-CAL AUDIT AND APPEAL PROCESS

19. As indicated above, under state law, the Department must audit the cost reports of hospitals furnishing long-term care services in distinct parts of the hospital at least annually. The audits are used for Medi-Cal rate setting purposes. Welf & Inst. Code § 14170(b). The rates, in turn, are the amounts to be charged for Medi-Cal services under 22 C.C.R. Sections 1546(g) and 51511.

20. In addition to requiring the Department to audit the "costs reported" by hospital providers of long-term care services, the state law also requires the Department to audit "amounts paid" to providers to insure responsibility and accountability for the expenditure of federal and state funds. Welf. & Inst. Code § 14170(a)(1).

21. Pursuant to Welfare and Institutions Code Section 14171, the Department has established an administrative appeal process to review grievances or complaints of providers arising from the findings of an audit or examination made pursuant to Welfare and Institutions Code Section 14170. 22 C.C.R. §§ 51016-51047.

22. Providers are furnished formal administrative hearings to challenge adverse Medi-Cal audit findings. The formal hearings are presided over by administrative law judges employed by the Department, who issue proposed decisions. The proposed decisions are reviewable by the Director of the Department, who ultimately must make the final agency determination.

23. The final agency decision of the Director of the Department is reviewable pursuant to Code of Civil Procedure Section 1094.5. Welf. & Inst. Code § 14171.

THE FACTS

24. As a health care district, Palomar Pomerado is governed by an elected board of directors. Its mission is to serve all patients in its district with quality and cost-effective health care services.

25. In order to provide continuity of care to its patients after they no longer require acute care hospital services, Palomar Pomerado purchased Palomar Continuing Care Center and built Villa Pomerado in the mid-1980's. Villa Pomarado and Palomar Continuing Care Center strive to provide high quality services in a cost-effective manner. Medi-Cal patients, unlike self-pay patients, require special approval from the Department in order to obtain covered nursing facility services. Before a distinct part nursing facility unit of a hospital can receive the distinct part nursing facility Medi-Cal payment rate, which is higher than the Medi-Cal rate paid to free-standing nursing facilities, the provider must obtain special approval of the need for the services to be furnished by the provider from a Medi-Cal consultant employed by the Department. Welf. & Inst. Code § 14091.21. Villa Pomerado and Palomar Continuing Care Center obtained approval to receive the distinct part nursing facility reimbursement rate for all of the Medi-Cal patients at issue here.

26. In the late 1980's, Palomar Pomerado implemented an acuity system of billing at Villa Pomerado and Palomar Continuing Care Center. The acuity system used a variety of treatment factors to determine a patient's level of acuity and the resulting need for services. Not surprisingly, the room rate for the lowest acuity level,

Level A, corresponded with the room rates of competing free-standing nursing facilities since those free-standing nursing facilities tended to treat the least ill patients. While well intended, the acuity system of billing proved difficult to administer. Moreover, during the period in which the acuity billing system was in place, it was not unusual for most private-pay patients to be assigned an acuity Level A, while most Medi-Cal patients were assigned an acuity level of C.

27. Due to various problems with the acuity system of billing, Palomar Pomerado moved to a flat rate billing system for long-term care services in April 1994. Palomar gave advanced notice of the change in the billing policy to all patients at Villa Pomerado and at Palomar Continuing Care Center in February 1994. The change to a flat rate system was intended to simplify the room rate charges.

28. At this same time, Palomar Pomerado instituted a prompt-pay discount. The prompt-pay discount applied only to charges for routine (room and board) services, and not to ancillary services, such as laboratory services, or to miscellaneous service charges.

29. The Department annually notified Palomar Pomerado of its Medi-Cal billing rate for the distinct part nursing facility services in letters sent by the Department to the administrators of the distinct part nursing facilities. Those letters indicated that the Medi-Cal payment rates were based on the lesser of costs, as projected by the Department, or the prospective class median rate. The letters also advised that "if your facility's charge to the general public for the same service is less than your final

DP/NF-B [distinct part nursing facility] rate, Sections 51480 and 51501, Title 22, C.C.R., require that the amount billed to Medi-Cal not exceed your public charge rate."

30. During each of the fiscal periods at issue, Palomar Pomerado submitted claims to the Department's Medi-Cal fiscal intermediary at the payment rate contained in the annual notices sent to Palomar Pomerado by the Department. In many cases, these payment rates were lower than the prospective class median rate and were based on Palomar Pomerado's costs of providing services to Medi-Cal patients, as projected by the Department. The Medi-Cal fiscal intermediary, in turn, paid Palomar Pomerado at the Medi-Cal payment rates established by the Department for the services furnished by Palomar Pomerado to Medi-Cal patients.

31. Because Medi-Cal payment rates do not vary with the acuity level of the Medi-Cal patients, the Medi-Cal payment rates received by Palomar Pomerado did not vary with the acuity level of the long-term care services furnished to the Medi-Cal patients. Once Palomar Pomerado eliminated the acuity level billing system, Palomar Pomerado continued to charge the Medi-Cal payment rates established by the Department. Thus, for example, assuming a semiprivate room charge of $200.00 per day, a prompt-pay discount of $100.00 per day, and a Medi-Cal payment rate of $150.00 per day, Palomar Pomerado billed Medi-Cal at the rate of $150.00 per day even though it billed self-pay patients at the discounted rate of $100.00 per day.

32. Well after services were provided and well after the Medi-Cal fiscal intermediary paid Palomar Pomerado

at the Medi-Cal payment rates established by the Department, the Department's Medi-Cal auditors conducted audits and/or "billing reviews" of Palomar Pomerado's records for the period of July 1, 1989 through June 30, 1994. Because the Medi-Cal auditors observed that Palomar Pomerado billed Medi-Cal at the payment rates determined by the Department regardless of the acuity level of the services required by the Medi-Cal patients, and because Palomar Pomerado gave the Medi-Cal program no prompt-pay discounts or other discounted rates for long-term care services furnished to Medi-Cal patients, the Medi-Cal auditors alleged that Palomar Pomerado had engaged in "discriminatory billing." Thus, using the figures contained in the above example, the Medi-Cal auditors alleges that Medi-Cal had been overcharged and thus Palomar Pomerado had been overpaid for services furnished to Medi-Cal beneficiaries in an amount equal to $50.00 per day for each day of services furnished by Palomar Pomerado to Medi-Cal patients. The $50.00 per day overpayment is the difference between the $150.00 Medi-Cal rate and the $100.00 "discounted" rate accepted by Palomar Pomerado for self-pay patients. Even though the number of patients receiving "discounted" rates was substantially less than the number of Medi-Cal patients treated by Palomar Pomerado, the Medi-Cal auditors calculated the Medi-Cal overpayments by applying the "discounted" rate to each and every day of services furnished to each and every Medi-Cal patient. The resulting overpayment calculated by the Medi-Cal auditors was approximately $15,000,000.00 for services furnished between July 1, 1989 and June 30, 1994.

33. Palomar Pomerado timely appealed the Medi-Cal auditors' findings and assessment of the overpayment to the Department's administrative hearing division. Palomar Pomerado contended that the findings were inconsistent with the controlling federal Medicaid laws and regulations and the governing state laws and regulations, and were arbitrary and capricious. Palomar Pomerado also contended that the assessment of the overpayments for certain periods was untimely. An administrative hearing was subsequently held.

34. On April 26, 1999, the Department's administrative law judge assigned to the case by the Department issued a proposed decision granting the appeal in part and denying the appeal in part. The granting of the appeal was based solely on a procedural irregularity regarding the audit of certain fiscal years. However, the proposed decision upheld the substance of the Medi-Cal auditors' findings. On April 27, 1999, the day following the issuance of the proposed decision, the Chief Deputy Director of the Department adopted the proposed decision as the final decision of the Department.

35. According to the final decision, even though a provider is prohibited by the Department's regulations from furnishing a discount for health care services furnished to a Medi-Cal beneficiary (Decision, ¶ VIII, p. 14), Section 51501 of the Department's regulations nevertheless prohibits a provider from charging Medi-Cal more for any article or service than the provider charged for that article or services to other purchasers. Final Dec. ¶ IX, p. 14. Because the services furnished to non-Medi-Cal patients, specifically, self-pay patients, were "comparable" to the services furnished to Medi-Cal patients, the

charges should have been the same, according to the final decision. Because they were not, the final decision upholds the auditors' findings and assessment of overpayments for all services except those services furnished during the 1992, 1993 and 1994 fiscal years at Palomar Continuing Care Center and for the 1994 fiscal year at Villa Pomerado. The findings and assessment for those periods were reversed due to a procedural irregularity.

THE INVALIDITY OF THE FINAL DECISION

36. To the extent it is adverse to Palomar Pomerado, the final decision of the Department is invalid and must be set aside for the following reasons, among others:

a. The final decision is inconsistent with the governing federal Medicaid law and state Medi-Cal statutes governing payment rates for long-term care services furnished in distinct part nursing facilities of hospitals. Specifically, the governing federal Medicaid law, 42 U.S.C. § 1396b(i)(3), only allows a state Medicaid agency to limit payment to a provider's customary charges for *inpatient hospital services*, as opposed to long-term care services. Similarly, under welfare and Institutions Code Section 14091.21 and 22 C.C.R. § 51546(g), Medi-Cal payment for the services at issue was required to be made at the Medi-Cal payment rates for such services established pursuant to 22 C.C.R. Section 51511, which contains no usual or customary charge limit.

b. Palomar Pomerado did not, in fact, impose different "charges" for the same services. Instead, the charges to all patients were the same for the same services.

c. Rather than selectively comparing the rates of payments for isolated components of long-term care services, such as the rates for room and board services, the Department was required to have compared the charges for the total long-term care services furnished to Medi-Cal patients with the charges for total services furnished to non-Medi-Cal patients, including self-pay patients. For example, although the rates for the room and board accepted by Palomar Pomerado for self-pay patients were less than the rates accepted from Medi-Cal for room and board services, the rates accepted by Palomar Pomerado for the *total* services furnished daily to Medi-Cal patients (including ancillary services), were comparable or less than the rates accepted by Palomar Pomerado for the total services furnished to the non-Medi-Cal patients, including private-pay patients.

d. Limiting Medi-Cal payment for the component of the long-term care services at issue (room and board) to the rates accepted for such services furnished to self-pay patients is arbitrary and capricious because it discourages providers from giving prompt-pay discounts and discounts to self-pay patients for health care services contrary to public policy as articulated by the state courts, *see People v. Duz-Mor* (1998), 68 Cal.App. 4th 654, and the California Legislature, *see* Section 657 of the Business and Professions Code, as amended by Senate Bill 1255 (1998). It is also inconsistent with Congressional intent indicating that "a nominal charge" should not be considered in calculating a public provider's usual or customary charges under federal Medicare and Medicaid law. *See* Social Security Amendments of 1972, Public Law 92-603, Section 233. Moreover, the discounting practice

actually saved the Medi-Cal program money by allowing self-pay patients a longer period of treatment before becoming eligible for Medi-Cal and by maintaining the census in the facilities so that the average costs per day were not higher than they otherwise might have been.

e. The final decision is arbitrary and capricious because the Department concludes that Palomar Pomerado violated the governing Medi-Cal regulations by "charging" less for Medi-Cal services than for services furnished to non-Medi-Cal patients. Yet, the final decision confirms that a provider is prohibited from offering or furnishing discounts for services furnished to Medi-Cal patients.

f. In any event, the amount of the overpayment assessed is arbitrary and capricious because the Medi-Cal program should be entitled to no greater total dollar discount for each fiscal year at issue than Palomar Pomerado gave to non-Medi-Cal patients; and

g. In any event, the assessment of the overpayment is untimely and unauthorized for those claims paid more than three (3) years before the Department's Medi-Cal auditors assessed the overpayments. The three-year audit period may not be circumvented by calling the audits "billing reviews" since the auditors did not, in fact, review Palomar Pomerado's Medi-Cal bills.

WHEREFORE, Palomar Pomerado prays as follows:

1. For a peremptory writ of mandate to be issued by the Court pursuant to Code of Civil Procedure Section 1094.5 setting aside the Department's final decision and reversing the adverse audit findings and assessment of overpayment;

2. For costs of suit; and

3. For such other and further relief as the court may deem just and proper.

Dated: June 28, 1999

Respectfully submitted,

HOOPER, LUNDY &
BOOKMAN, INC.
PATRIC HOOPER

By: /s/ Patric Hooper
Patric Hooper
Attorneys for Petitioner
Palomar Pomerado
Health System